STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

Case Management

Reimbursement Methodology for Case Management Services as described in Supplement 1g to Attachment 3.1-A

Case management services will be provided by licensed and certified Public Health Nurses (PHN) who are experienced in providing case management services and who are employed by a jurisdiction's local health department.

Reimbursement rates shall be established for a specific unit of service. The unit of service shall be an encounter with Title XIX eligible infants, children, and young adults to age 21.

An encounter is defined as a face-to-face contact or a significant telephone contact with the Title XIX eligible individual or with the individual or legal guardian designated to act on behalf of the Title XIX eligible individual.

The reimbursement process is as follows:

1. The Department of Health Services, Childhood Lead Poisoning Prevention Branch (CLPPB) budget for fiscal year 1996-97, includes State General Funds for the provision of Medi-Cal Lead Poisoning Case Management Services to lead poisoned Med-Cal eligibles to age 21 by each jurisdiction's local health department.

2. For each jurisdiction's local health department, the CLPPB will calculate the estimated amount of per encounter costs based upon the statewide average cost of a Public Health Nurse (PHN) Medi-Cal Lead Poisoning Case Management encounter, the number of each jurisdiction's local health department's Medi-Cal eligibles to age 21 at risk for lead poisoning, and the number of each jurisdiction's local health department's lead poisoned Medi-Cal eligibles to age 21 currently receiving case management services.

3. The projected amount of State General Funds set aside for each jurisdiction's local health department will enable jurisdiction's local health departments to develop an annual Medi-Cal Lead Poisoning Case Management budget.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

Case Management

Reimbursement Methodology for Case Management Services as described in Supplement 1g to Attachment 3.1-A (continued)

Claims for federal financial participation reimbursement will be made retrospectively after Medi-Cal Lead Poisoning Case Management services have been provided and documented in each Medi-Cal eligible's chart and PHN personnel time is documented.

4. Each jurisdiction's local health department will conduct a regularly scheduled time study following federal OMB A-87 approved time study methodology. The time study will capture the PHN time spent providing case management services to both Medi-Cal and non-Medi-Cal eligibles in one or more components of case management services, such as assessment, plan development, referral, assistance in accessing services, follow-up crisis intervention planning, reevaluation, or on other activities that are directly related to the provision of case management services.

5. Each jurisdiction's local health department will establish a rate for case management services provided to Medi-Cal eligibles. The rate will be derived from the annual budget, which contains salary and benefits, and time studies that show time spent performing case management services, including travel. The total cost of providing case management services to Medi-Cal eligibles will be divided by the total number of Medi-Cal eligibles receiving case management services during the time-study period to arrive at a rate per Medi-Cal eligible.

6. Each jurisdiction's local health department will develop invoices for reimbursement of case management services provided to Medi-Cal eligibles. Invoices will be submitted quarterly to the Childhood Lead Poisoning Prevention Branch.

7. Each jurisdiction's local health department will maintain documentation in support of invoices submitted for case management services. The documentation will include:
   a. Date of service,
   b. name of Medi-Cal eligible,
   c. name of provider agency and person providing the case management service,
   d. nature, extent, or units of service,
   e. place of service, and
   f. completed time study for each case manager.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

Case Management

Reimbursement Methodology for Case Management Services as described in Supplement 1g to Attachment 3.1-A (continued)

8. Fiscal monitoring will be conducted using an audit trail that includes a) the name, classification, duty statement, and amount of PHN time identified on the local health jurisdiction's budget submitted to and approved by the DHS/CLPPB; b) quarterly invoices submitted for reimbursement of PHN case management services; c) the time study identifying PHN time spent providing Medi-Cal Lead Poisoning Case Management services; and d) the PHN's field record documenting the recipient's Medi-Cal status, lab report documenting the Medi-Cal recipient's elevated blood lead level, the CLPPB Follow-up Form and PHN service plan that documents receipt of necessary follow-up activities.

9. The department shall ensure free care and third party liability requirements are met.

10. The department shall conduct an annual survey of insurance carriers to determine whether case management services, as described in this State Plan Amendment, are included and paid for as a covered benefit. The survey result will be used to determine the extent of Medicaid's payment liability in accordance with federal regulations set forth in 42 CFR 433.139(b).

STATE PLAN UNDER TITLE XIX OF SOCIAL SECURITY ACT

STATE California

REIMBURSEMENT LIMITS FOR PROFESSIONAL SERVICES

The policy of the State Agency is that reimbursement for each of the other types of care or service listed in Section 1905(a) of the Act that are included in the program under the plan will be at the lesser of usual charges or the limits specified in the California Administrative Code, Title 22, Division 3, Chapter 3, Article 7 (commencing with Section 51501).

The methodology utilized by the State Agency in establishing payment rates will be as follows:

(a) The development of an evidentiary base or rate study resulting in the determination of a proposed rate.

(b) The presentation of the proposed rate at public hearing to gather public input to the rate determination process.

(c) The determination of a payment rate based on a evidentiary base including pertinent input from the public hearing process.

(d) The establishment of the payment rate through the State Agency's adoption of regulations specifying such rate in the California Administrative Code, Title 22, Division 3, Chapter 3, Article 7 (commencing with Section 51501).

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State: California

(e) Notwithstanding any other provisions of this Attachment to the State Plan pertinent to the methods and levels of reimbursement to providers, rates may be adjusted when required by state statute provided that applicable requirements of 42 CFR Part 447 are met.

(f) (1) In addition, at the beginning of each fiscal year, for the current fiscal year, the director shall establish a monthly schedule of anticipated total payments and anticipated payments for categories of services, according to the categories established in the Governor's Budget. The schedule will be revised quarterly. The director shall report actual total payments and payments for the categories of services monthly to the Director of Finance and to the Joint Legislative Budget Committee.

(2) At any time during the fiscal year, if the director has reason to believe that the total cost of the program will exceed available funds, the director may, first modify the method or amount of payment for services provided that no amount shall be reduced more than 10 percent and no modification will conflict with federal law. At any time during the fiscal year, if the total amounts paid since the beginning of the fiscal year exceed by 10 percent the amounts scheduled, the director shall immediately institute such modification.

(3) At any time during the fiscal year, if the total amount paid for any category of service in the Governor's Budget exceeds by 10 percent the amounts scheduled for that category of service (other than services for which the method or amount of payment is prescribed by the United States Secretary of Health and Human Services pursuant to Title XIX of the federal Social Social Security Act), the director shall modify the method or amount of payment for such category of service to assure that the total amount paid for such category of service in the fiscal year shall be less than 10 percent in excess of the total amount scheduled for the fiscal year for that category of service, provided the total cost of the program to the State General Fund will not exceed appropriated state general funds. If, on the other hand, the director has reason to believe that the total cost of the program to the State General Fund will exceed appropriated state general funds, the method or amount of payment may be further modified as provided in subparagraph (2).

State: California

(4) No modification in method or amount of payment will be made under this paragraph which does not meet all applicable requirements of 42 CFR Part 447. An analysis of provider participation, and the expected impact of any proposed modification on provider participation, will be completed before any modification of payments is made under this paragraph. Where necessary, adjustments to proposed or implemented modifications in method or amount of payment made under this paragraph will be made, to assure compliance with 42 CFR 447.204.

(5) Before any of the above actions are taken, the director shall consult with representatives of concerned provider groups.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Terrirory California

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES (OTHER THAN INPATIENT HOSPITAL, AND LONG TERM CARE FACILITIES).

X Case Management Services

See Case Management Rates (Attached).

Case Management Rates:

Following is the methodology for computing unit of service rates for Targeted Case Management Services/Regional Center Administrative Costs:

Each regional center will utilize an average targeted case management unit of service rate.

The computation of the rate is prospective and is established on the basis of historical costs.

1. Calculation of the unit rate for Targeted Case Management Services/Regional Center Administrative Costs is as follows:

   a. Determine the percentage of allowable time spent on case management services by the appropriate direct service staff. Percentages will be determined based on a time study for each direct service classification.

   b. Multiply the percentages by the applicable costs for each classification. Costs will be obtained during each rate study period.

   c. Determine the percentage of allowable costs for all direct service classifications and multiply times the administrative/other staff costs and operating expenses. Costs will be obtained during each rate study period.

   d. Summarize all allowable costs and divide by the units recorded during the rate study period to arrive at a unit rate for Targeted Case Management Services/ Regional Center Administrative Costs.

Billing System

Targeted Case Management Services will be documented by the Client Program Coordinator (CPC) on a Medicaid eligible, client specific activity log (See Attachment 1 which is an example of the documenting instrument to be employed by the CPC). The date of service, the CPC providing the service, the units of services (recorded in 15 minute increments of service time), an explanation of the type of service, and the location of the service will be recorded on the activity logs. The total units of service provided to each Medicaid recipient (eligible for Targeted Case Management Services) will then be tallied at the end of each month by the regional center and submitted to the Department of Developmental Services (DDS). A copy of the activity log will be retained in the client's case record for auditing purposes.

DDS will prepare a computer tape which contains the Medicaid eligible's name, sex, date of birth, Medicaid identification number, Social Security number, the provider number (regional center), the month the service was provided, and total units of services provided during the month. This tape will be run against the Single State Agency's (Department of Health Services[DHS]) master file of Medicaid eligibles. In California, this system is the Medi-Cal Eligibility Data System (MEDS).

An invoice will be prepared by the DHS and submitted to HCFA for all regional center clients receiving targeted case management services who have been verified as Medicaid eligible (via the computer match) for the month in which the service(s) was provided.

Submission of claims and resubmissions for initially rejected claims (due to erroneous data and not due to lack of Medi-Cal eligibility) will follow general Medi-Cal rules governing the timeliness of claims submission and will be specified in the interagency agreement between DDS and DHS.

User Fee System

Each developmentally disabled person who receives case management services, as defined in Section 1915 of the Social Security Act, his or her estate, his or her spouse and the parents of minor recipients, except the parents of minor recipients who do not reside in the same household as a parent or parents, shall be liable for fees for case management services. Fees for case management services shall not exceed the regional center's actual cost of services provided. Charges for these services will be billed, on behalf of any individual with third party insurance or benefit plan coverage for such services, to the insurance or benefit plan covering such service for that individual. Liable parties shall not be charged a fee for case management services included in a child's individualized education program established pursuant to Part B of the Individuals with Disabilities Education Act. Actual costs shall be determined in the manner specified previously under Case Management Rates.

Fees charged to individuals shall be determined in accordance with the following schedules:

For families of one or two persons, including the client and all members of the family residing in the same household:

Adjusted Gross Income Categories *(amount reported by liable party on most recent federal income tax return)*	Fee Factor *(% of the regional center's cost of services provided)*
$1 - $ 70,999	0%
$ 71,000 - $ 74,999	5%
$ 75,000 - $ 79,999	10%
$ 80,000 - $ 84,999	15%
$ 85,000 - $ 89,999	20%
$ 90,000 - $ 94,999	25%
$ 95,000 - $ 99,999	30%
$100,000 - $104,999	35%
$105,000 - $109,999	40%
$110,000 - $114,999	45%
$115,000 - $119,999	50%
$120,000 - $124,999	55%
$125,000 - $129,999	60%
$130,000 - $134,999	65%
$135,000 - $139,999	70%
$140,000 - $144,999	75%
$145,000 - $149,999	80%
$150,000 - $154,999	85%
$155,000 - $159,999	90%
$160,000 - $164,999	95%
$165,000 and over	100%

State/Territory: California

Citation	Condition or Requirement

E. ALLOWABLE SERVICES

Allowable services and units of service are as follows:

Service	Unit of Service
Day Care Rehabilitative	Minimum of three hours per day, three days per week.
Outpatient Drug-Free Treatment	Individual (50-minute minimum session) or group (90-minute minimum session) counseling.
Perinatal Residential Substance Abuse Treatment	24-hour structured environment (excluding room and board).
Naltrexone Treatment	Face-to-face contact per calendar day for counseling and/or medication services.
Narcotic Treatment Programs (aggregate rate consisting of four (4) components)	
1. Core	Intake assessment, treatment planning, physical evaluation, drug screening and physician supervision.

State/Territory: California

Citation		Condition or Requirement
2.	Laboratory	Tuberculin and syphilis test, monthly drug screening, and monthly pregnancy tests of female LAAM patients.
3.	Dosing	Ingredients and dosing fee for methadone and LAAM patients.
4.	Counseling	Minimum of fifty (50) minutes to be provided and billed in ten (10) minutes increments, up to a maximum of 200 minutes based on medical needs of the patient.